Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

AHMED KHALIFA, MD
3100 TIMMONS LN, STE250
HOUSTON, TX 77027

Respondent Name

UNIVERSITY HEALTH SYSTEM

Carrier's Austin Representative Box

Box Number 17

MFDR Tracking Number

M4-12-0745-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement was provided by requestor.

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The issue is in regards to the methodology used to determine the reimbursement amount for the impairment rating. The provider's position statement is a generic form letter, which does not provide rationale as to why the prior reimbursement was incorrect….In summary, no additional allowance is due. The medical records indicate the impairment rating was determined by the DRE method and reimbursement was in accordance with the Medical Fee Guidelines."

Response Submitted by: Argus Services Corporation, 9101 LBJ Freeway, Suite 600, Dallas, Texas 75243-2055

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 18, 2011	99456-W5-WP	$150.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   Explanation of benefits dated August 16, 2011
   - W1B Workers Compensation State Fee Schedule Adjustment*Reimbursement per Rule 134.204/134.204 for Impairment rating done by Diagnosis Related Estimates (DRE) method. Prior to March 1, 2008, Rule 134.202.*

   Explanation of benefits dated October 11, 2011
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - W1B Workers Compensation State Fee Schedule Adjustment*Reimbursement per Rule 134.204/134.204 for Impairment rating done by Diagnosis Related Estimates (DRE) method. Prior to March 1, 2008, Rule 134.202.*

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement for disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The provider billed the amount of $1,150.00 for CPT code 99456-W5-WP for a DD examination for Maximum Medical Improvement/Impairment Rating (MMI/IR). Review of the documentation supports that MMI was assigned and one body area/condition was rated. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I), the MAR for an IR using Diagnosis Related Estimates (DRE) Category II method on the lumbar (spinal region) is $150.00. The MAR for the MMI/IR services rendered is $500.00.
2. The respondent has already reimbursed the amount of $500.00 for the disputed CPT code 99456-W5-WP. Therefore, the requestor is not entitled to additional reimbursement

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 29, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.
Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.